Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Spire Norwich Hospital/Spire Healthcare Limited** [redacted]
1	**CORONER** I am JACQUELINE LAKEJacqueline LAKE, HM Senior Coroner for the coroner area of NORFOLKNorfolk
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 17 August 2022 I commenced an investigation into the death of Geoffrey Douglas HOAD aged 85. The investigation concluded at the end of the inquest on 07 September 2023. **The medical cause of death was:** 1a) Sub Acute Myocardial Infarction 1b) Coronary Artery Atherosclerosis 1c) 2) Hospital Admission for Post Operative Ileus **The conclusion of the inquest was:** Mr Hoad underwent an appropriate, elective medical procedure on 3 August 2022, following which a paralytic ileus was diagnosed. Mr Hoad's condition fluctuated and did not respond to conservative management. The decision was made to transfer Mr Hoad to Norfolk and Norwich University Hospital at approximately 18.00 on 6 August 2022 and an ambulance called. The ambulance arrived at 08.26 hours on 7 August 2022. Mr Hoad's condition continued to fluctuate. At 18.50 Mr Hoad rapidly deteriorated and he died at 23.45 hours.
4	**CIRCUMSTANCES OF THE DEATH** On 3 August 2022, Mr Hoad underwent a total hip replacement at The Spire Hospital. On 5 August 2022, Mr Hoad was diagnosed with a paralytic ileus and some respiratory compromise with gradually deteriorating renal function. On 6 August 2022, Mr Hoad's transfer to Norfolk and Norwich University Hospital was agreed due to possible bowel obstruction, possible pulmonary infection and deteriorating renal function. Ambulance service was called at 18:16 hours and again at 23.45. On 7 August 2022, the ambulance service was called again at 07.38 hours. The ambulance was on scene at 0826 hours. Mr Hoad was transported to Norfolk and Norwich University Hospital. At 11.30 am ECG was undertaken which showed signs of cardiac ischaemia. The evidence does not reveal whether this ECG was reviewed. The cardiac ischaemia was not noted and acted upon at this time. By 18.52 Mr Hoad had clinically deteriorated with continued low blood pressure and increased oxygen requirements. A repeat ECT showed ongoing ischaemia which was recognised, and Mr Hoad was taken to Critical Care Complex at 20.18 hours with a diagnosis of myocardial infarction. Despite treatment, Mr Hoad continued to deteriorate, and he died later that day on 7 August 2022.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: 1. Spire Norwich Hospital called the ambulance service on 6 August 2022 at 18.16 hours. The call was coded as a Category 3 call, requiring a response within 2 hours. The Spire Hospital were told the response would be 6 hours. 2. The ambulance service was called again at 23.45 hours and the call was again coded as a Category 3 call. 3. The ambulance service was called again on 7 August 2022 at 07.38 hours and the call was now coded as a Category 2 call, requiring a response within 40 minutes and with an average time of 18 minutes. 4. Due to continuing demand on the ambulance service, an ambulance did not become available until 08.16 hours. The ambulance arrived on scene at 08.26 hours. 5. The time between calling the ambulance service and an ambulance arriving was in excess of 14 hours. 6. Evidence was heard as to the very high call demand overnight on 6th and 7th August 2022 and with regard to the significant pressure the healthcare system was and remains under. 7. Evidence was also heard as to the steps being taken by EEAST in an attempt to deal with this pressure on the healthcare system. 8. Despite the steps being taken by the EEAST, considerable delays in attending to calls continue. 9. Spire Norwich Hospital does not deal with multi-disciplinary and emergency treatment at its hospital and transfers patients requiring such treatment to local acute Trusts, usually the Norfolk and Norwich University Hospital. 10. Spire Norwich Hospital continues to rely on EEAST to transport such patients to the acute hospital, being fully aware of the demands placed on the EEAST generally and the delays which occur as a result. 11. At the inquest Spire Norwich Hospital placed great reliance on now being part of an Interfacility Transfer Group led by the Norfolk and Norwich University Hospital working with the EEAST to look at a pathway in respect of inter hospital transfers. The evidence of EEAST was that this pathway was not expected to reduce delays in inter hospital transfers. 12. This concern has been raised at previous inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by November 06, 2023. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION**

	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] East of England Ambulance Service NHS Trust Norfolk and Norwich University Hospitals NHS Foundation Trust I have also sent it to: Department of Health CQC HSIB Healthwatch NHS England & NHS Improvement, who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 13/09/2023** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH